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Medical Same Day Emergency Care (Medical SDEC)

Jonathan Page (Lead Nurse)

18/05/2022

What is Medical SDEC

- SDEC is the provision of same day care for emergency patients who would otherwise be admitted to hospital.
- Under this care model, patients presenting at hospital with relevant conditions can be rapidly assessed, diagnosed and treated without being admitted to a ward, and if clinically safe to do so, will go home the same day their care is provided.
- If SDEC did not exist the patient would otherwise need admission to hospital.

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Medical SDEC in Barnsley

- Led by a Consultant in Acute Medicine who works 10:00-18:00
- All nurses are experienced in Acute Medicine and run a Nurse Led VTE Clinic
- Physician Associates, Registrars and Junior Doctors.
- Open 08:00-20:00 Monday to Friday and some weekends.
- Nurse Led VTE Clinic open 08:00-20:00 7 days a week.

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AMAC to SDEC What's Changed?

- Purpose built department
- Located next to ED
- Co-located with Surgery
- Two monitored beds
- Ability to see patients of higher acuity
- Same team but with increased medical staffing and a dedicated Lead Nurse

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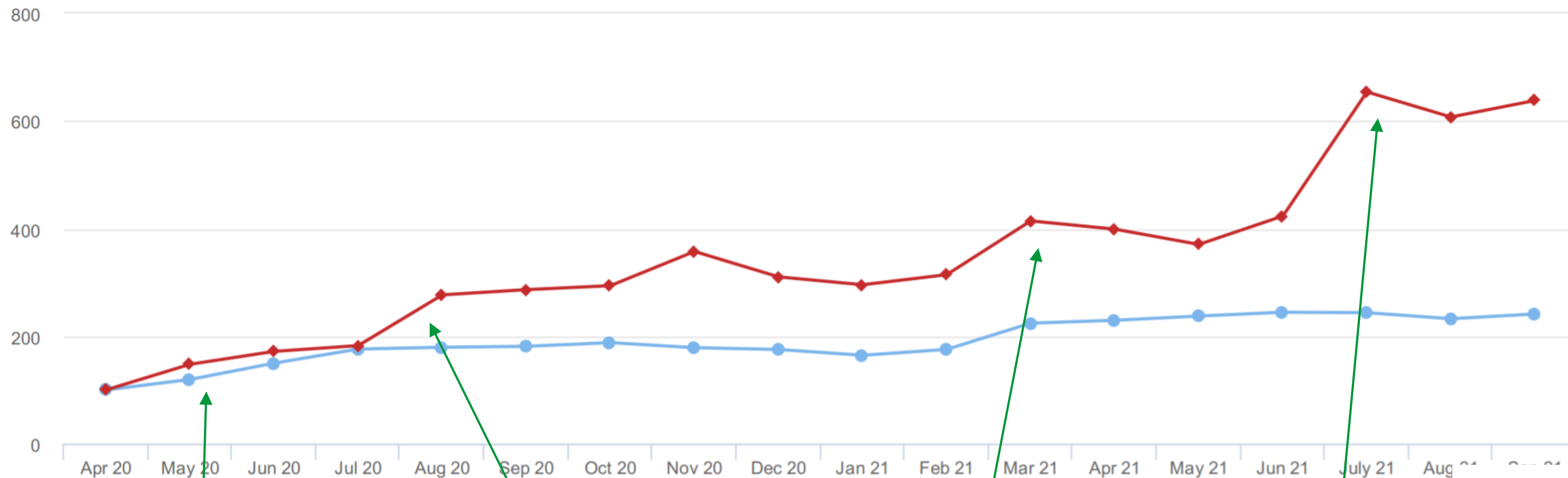
Successes

- 100% increase in patients seen
- Average length of stay remains 4-5 hours
- Conversion to admission remains 10%
- 98% of patients rated Medical SDEC as good or very good
- Over 50% of patients referred to hospital by their GP seen in Medical SDEC rather than AMU
- 30% of all medical take seen

National Benchmarking

Barnsley Hospital NHS Foundation Trust

BHNFT MSDEC (red) all activity V National Average (blue)



VTE service running but AMAC closes (1st wave Covid)

Smaller AMAC opens in phelobotomy

QI Work begins

New admission criteria from ED

Accepting from clinician in ED hub

Increased engagement with ED

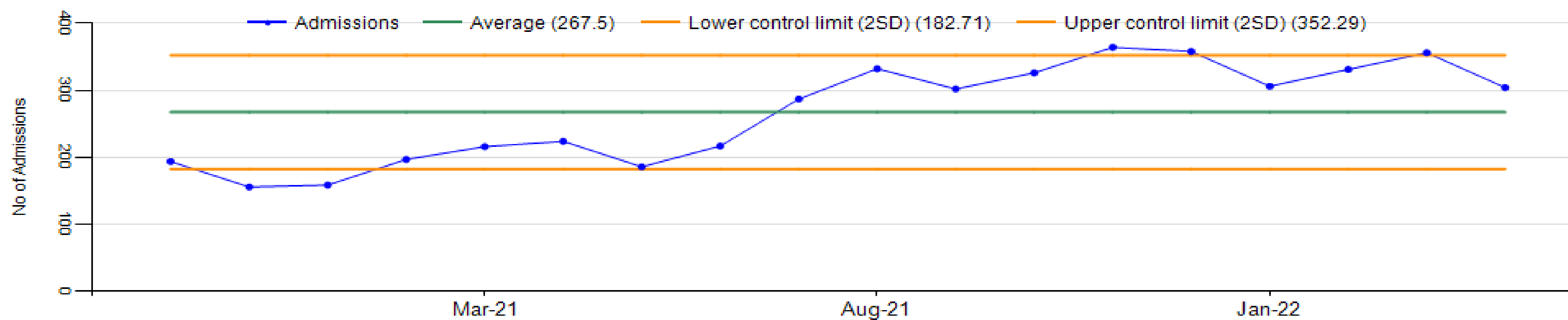
DVT Front door pathway

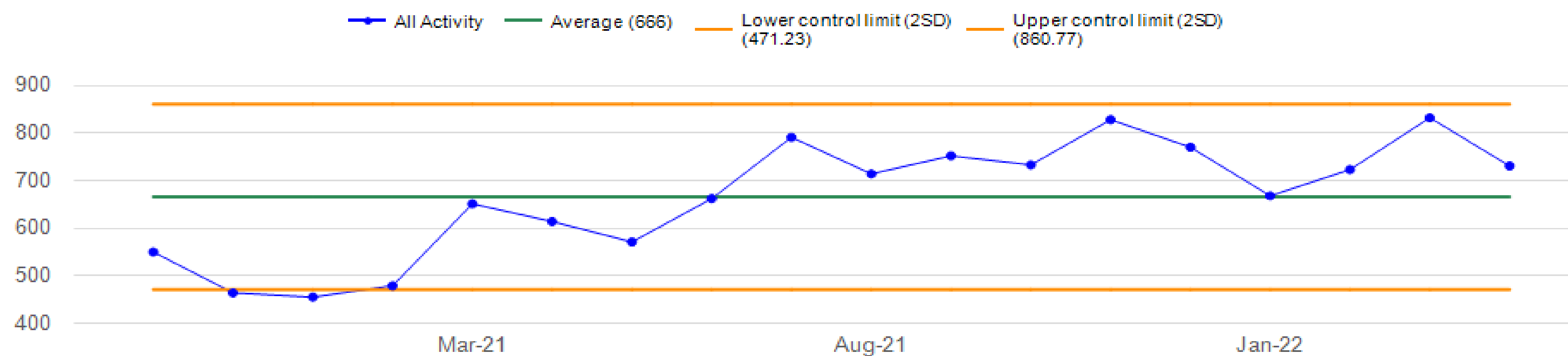
New Medical SDEC opens

Regular pull from ED

Full time MSDEC lead nurse

Rightcare triage through MSDEC


MSDEC Admissions (direct admissions or transferred in)
Admissions
Average (267.5)
Lower control limit (2SD) (182.71)
Upper control limit (2SD) (352.29)
No of Admissions
0
100
200
300
400
Mar-21
Aug-21
Jan-22


All Activity (Inpatients and Outpatients)
All Activity
Average (666)
Lower control limit (2SD) (471.23)
Upper control limit (2SD) (860.77)
900
800
700
600
500
400
Mar-21
Aug-21
Jan-22

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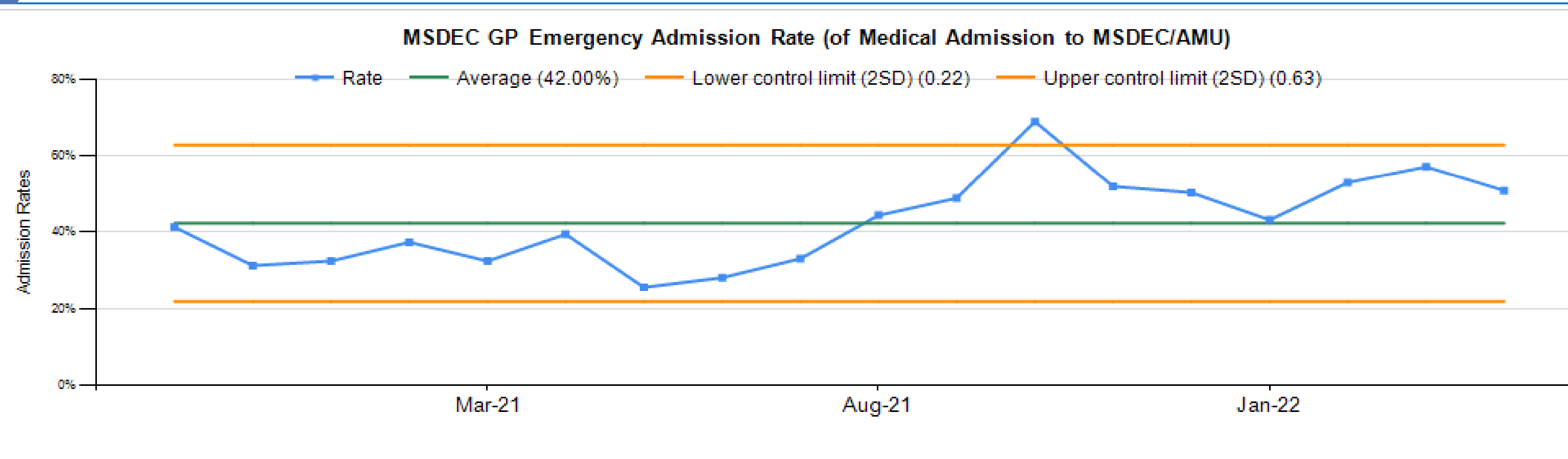

Challenges

- Availability of Acute Medical Consultants
- Opening hours
- Limited resource
- Referral consistency and ingraining pathways
- Balancing acuity of patients and when the service becomes inappropriate.
- Transferring patients in to inpatient wards.

Workstreams

- Emergency Department – Pull, Push and Pathway
- Yorkshire Ambulance Service
- Acute Medical Wards
- Outpatient Clinics
- Clinical Nurse Specialists
- Community Services
- 111/DOS
- GP

NHS Yorkshire Ambulance Service NHS Trust

RightCare Barnsley

SAME DAY EMERGENCY CARE (SDEC)

CLINICAL PATHWAY AVAILABILTY AND ASSESSMENT

Barnsley Hospital NHS Foundation Trust NHS

For patients who may require hospital treatment for a condition but can avoid an ED admission / attendance

- This pathway is open to all YAS clinicians, Mon to Fri 08:00-18:00 (Medical) Mon to Sun 08:00-18:00 (Surgical)
- For stable patients with NEWS2 score ≤4

INCLUSION CRITERIA-SUITABLE TO REFER

- NEWS2 SCORE ≤4 & ≤3 IN ONE PARAMETER, 16 YRS OR OVER:

✓Do not require admission to ED (pre-alert)

✓Where patient is stable and low risk of deterioration

✓ Where community services are incapable of management (consider GP/SPA/ECP referral if appropriate)

✓ Fit-to-sit patients with low level acuity who are alert and orientated

Medical

Referral conditions include:

- Palpitations (with NO ECG changes and NO chest pain)
- Headaches without head injuries or increased confusion
- Non-symptomatic upper/lower GI bleeds
- GP URGENT INR reversal or spurious high potassium without ECG changes
- Unresolved cellulitis

Surgical

Referral conditions include:

- Post-operative complications / pain
- PR Bleeding
- Abscess
- Biliary Colic
- Right Upper Quadrant Pain
- ? Appendicitis

These lists are not exhaustive and clinicians are urged to call to discuss patients who they feel to be suitable for SDEC

EXCLUSION CRITERIA-UNSUITABLE TO REFER

- NEWS2 SCORE >4 & <3 IN ONE PARAMETER
- Acute delirium or advanced dementia
- Unfit-to-sit patients and those with high level acuity
- Patients with suicidal ideation and those requiring 1-2-1 supervision
- Ongoing chest pain and/or ECG changes
- Trauma related problems.
- Confirmed diagnosis requiring inpatient stay
- Patient requires specialist pathway such as stroke,PPCI, acute vascular emergencies etc.
- Where patient could be seen/treated in the community

REFERRAL PROCESS

- Complete a full assessment as normal
- Ensure inclusion criteria are met and no exclusions are evident

Call **Rightcare Barnsley** on **01226 431333** to refer

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Which patients can be referred to medical SDEC?

Gastroenterology:
- Upper GI bleed with Rockall score of **1**
- Painless obstructive jaundice
- Non-acute abdominal pain
- Gastroenteritis
- PEG related complications (in hours only)
- Abnormal LFTs

Cardiology:
- Low probability chest pain- see support document
- AF –haemodynamically stable, rate<130
- Syncope- see ED TLOC pathway and AMAC support document for details
- Hypertension
- CCF

Endocrinology:
- Hyperglycemia **without** ketosis
- Hypoglycemia with full recovery
- Type 1 Diabetes **without** ketosis
- Electrolyte imbalances
- Thyroid disease

Miscellaneous conditions:
- Anaemia

Neurology:
- Seizure in known epileptic
- Acute headache with no neurological deficit

Respiratory Diseases:
- Pulmonary Embolism
- Primary pneumothorax **≤2cm**
- Pleural Effusions
- Community acquired pneumonia **CURB≤2**
- Asthma- see support doc.
- COPD

Infectious Diseases:
- Cellulitis
- Osteomyelitis- diabetic foot related and if not for orthopaedic intervention
- Urinary tract infections

Any patient with a medical problem and ALL of the below:
- **NEWS <4**
- **Clinically judged as stable & fit to sit in a chair**
- **Not acutely confused**
- **Clinically judged as suitable for a COLD area**
- **Able to mobilise independently**
- **No social issue**

Please see SDEC Criteria support document for further clarification for conditions on this poster.

We operate Monday - Friday 10am - 6pm

We're keen to accept referrals for any patients that fit the above criteria

If in doubt contact nurses on 2452

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Nurse Led VTE Clinic

- Based on NICE NG 158 ‘Venous thromboembolic diseases: diagnosis, management and thrombophilia testing’
- Wells 2 Score and bloods including D-Dimer
- If either positive then USS Doppler
- If scan negative and D-Dimer raised then rescan 6-8 days
- Designated scan slots daily
- Patients involved in decisions on treatment
- All positive VTE’s are seen by Consultant

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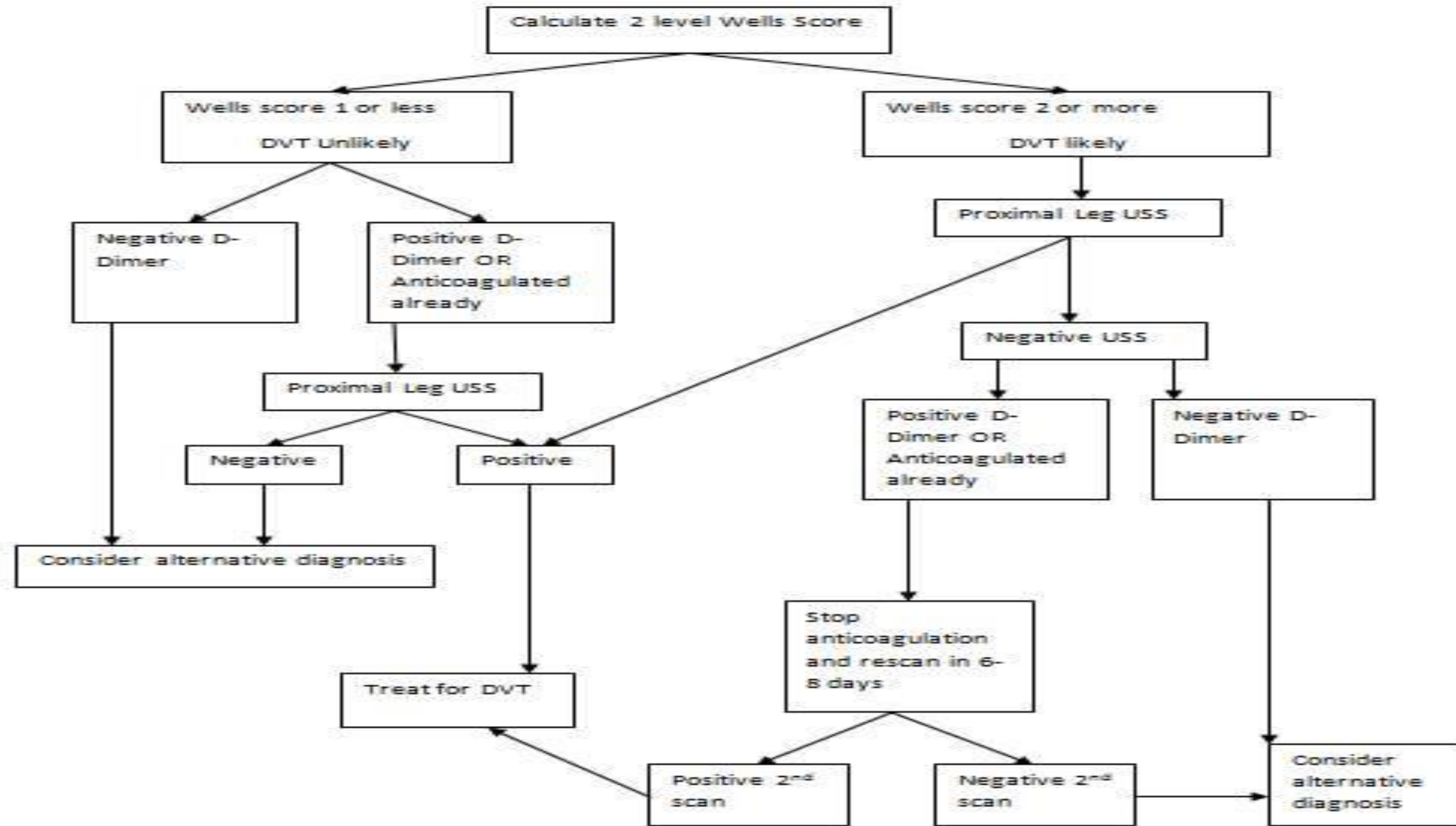

A 2nd proximal leg Doppler following the 1st negative proximal leg Doppler is only required if the patient has a high wells score (DVT likely) and a positive D-dimer (or already anticoagulated in a therapeutic range).

VTE Follow Up

- If unprovoked then investigation into causes
- Counselling on treatment
- Health advice
- Fennerty Loading and daily INR's provided by service
- Referred to anti-coagulation clinic once INR within range
- Followed up by Consultant in 3 months (provoked) and 6 months (unprovoked).

What’s next for Medical SDEC?

- Further pathways from ED
- DOS
- Increased opening hours
- Service evaluation
- Acute Oncology Pathways
- Work with primary care

How can primary care help?

- Start treatment for VTE’s
- Follow up bloods post discharge
- Management of chronic conditions
- Refer appropriately
- Avoid ED
- Discuss when unsure
- Don’t use Medical SDEC to avoid two week waits

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Clinical Case Studies

Presented by Siobhan Stanton

Sister AMU and Medical SDEC

Giant Cell Arteritis

- 67 year old female
- PMH - hypothyroidism, hypercholesteremia
- PC – 6/52 headaches, jaw ache and vision loss
- Patient journey –
  - Day 1 GP telephone consultation, attendance at ophthalmology and then sent to ED.
  - Day 2 Returned to SDEC (ED referred out of hours)
  - Day 3 Patient seen in rheumatology

Giant Cell Arteritis

- What did SDEC do?
- Patient seen by Acute Medical Consultant and discussed with rheumatology
- Treatment commenced
- Rheumatology follow up arranged
- Treatment continued daily for 3/7
- Patient remained under ophthalmology and rheumatology post discharge from SDEC

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Anaemia

- 26 year old male
- PMH – Crohns and anaemia
- PC- Bloods at GP showed HB 65
- Patient journey –
  - Day 1 GP called patient and told patient to attend ED
  - Day 2 Patient attended ED and pulled to SDEC

Anaemia

- What did SDEC do?
- Transfused 2 units RBC
- Gastro follow up
- Follow up bloods arranged in 1/52
- Patient initiated follow up for 1/52

Osteomyelitis

- 68 year old male
- PMH – T2DM, peripheral neuropathy, HTN, AF
- PC – Infected chronic foot ulcer
- Patient attended ED and was admitted to AMU
- Discharged from AMU next day
- SDEC gave daily teicoplanin
- Surgical team debrided wound
- Followed up in Diabetic Foot Clinic

Osteomyelitis

- What did SDEC do?
- Daily IV teicoplanin
- Facilitated early discharge from AMU
- Acted as main liaison for specialty care including foot clinic and surgical debridement.

Collaborative Working Case Study

- 38 year old male
- History- 2019 gastroscopy and colonoscopy and referred to Surgical Team. Was never followed up.
- PC – Anaemia
- Patient journey-
  - Direct referral to Medical SDEC
  - Medical SDEC worked with Surgical SDEC to investigate patient
  - Followed up in PIU and endoscopy

Collaborative Working

- Patient had 2 units RBC and Ferinject
- Surgical SDEC - rigid sigmoidoscopy and proctoscope which showed Grade 3 hemorrhoids.
- Surgical SDEC arranged outpatient capsule endoscopy
- Routine bloods in Medical SDEC 2/7 later
- Further RBC's given in PIU

Any Questions?